Cross-cutting Issue 3: The Best Structure for the State's Mental Health System (including tensions between the community-based system model and the health plan model, and centralized/localized)

Structure, Governance, and Accountability

Issue Statement

Michigan's public mental health system is not structured to deliver care effectively, efficiently, and in a timely fashion to people with mental illness. The current structure—that is, the relationships and responsibilities shared among the state, PIHPs, CMHSPs, providers, and consumers—has fostered the following problems:

- Huge variation in funding and therefore service provision and access. (See Cross-cutting Issue 4, Funding)
- Inefficiency because of variation in regulation between the two major funding sources. PIHPs struggle to manage two dramatically different major sources of funding for public mental health services: Medicaid and general fund. These sources have very different requirements, which confuse and frustrate people needing services and drive unnecessary duplication of effort in PIHPs that must conform to these regulations.
- While there has been some progress recently with clinical uniformity and data submission, there is inefficiency from an overabundance of uniform statewide administrative requirements and the absence of a standard method of collecting information from PIHPs, CMHSPs, and providers to meet administrative requirements. The state lacks the staffing and resources to monitor and enforce statewide standards when doing so will reduce administrative costs and improve quality.
- Too much variance in the quality of mental health care. In addition, federal and state regulations have been the basis of an accountability system that does not measure the things that matter most to consumers and reflect the commission's values. A quality management system must integrate compliance with quality measures that MDCH should set with input from consumers, PIHPs, CMHSPs, and providers. (The early work of MDCH's Quality Improvement Council is promising in this regard.)

Options

Form should follow function in the structure of the public mental health system in Michigan. Structure should preserve local delivery and oversight of services; involve consumers meaningfully in governance; ensure that services are necessary, high quality, and the best value for the community; and limit administrative costs to only those needed to accomplish the previous three objectives. To accomplish these objectives, the structure should combine standardization of certain functions (data, claims, financial management, performance reporting, and others), state ability to enforce agreed-upon standards, and local responsiveness to needs and local delivery of services.

- Original work group recommendation: Consolidate CMHSPs into at most 18 regional authorities/PIHPs. These single authorities will manage both Medicaid and general fund monies for public mental health services.
- Alternatives to consolidation/regionalization:
  - Create a true mental health *system* through a shared governance structure that better coordinates state, regional, and local roles and responsibilities for services to persons with mental illness. Such a structure depends on (a) improving and enforcing statewide standards for administration and performance (see below); (b) coordinating these functions regionally; and (c) preserving CMHSP local assessment and delivery.
  - Establish a task force or work group to examine the delivery and financing of mental health services in rural areas. This group should address the inequitable funding for mental health in rural Michigan and recommend changes to the current structure (PIHPs, CMHSPs) to assure that rural residents' needs are met.
  - Restore the locus of responsibility for public mental health services to MDCH and have an MDCH contract management unit—with monitoring and compliance authority—directly administer contracts with core providers at the local level.
- Invest more resources for MDCH to (a) continue setting standards for payment, performance, and other administrative functions (billing, computer systems) and (b) provide training in these areas so that accountability is achieved without micromanagement. Have the state and other stakeholders develop a uniform, unobtrusive way of standardizing administrative and performance monitoring systems and complying with federal regulations. This would draw on best practices from across the state and allow more funding to go to direct care.
- Strengthen MDCH enforcement. Once uniform administration and performance reporting standards have been improved, the state should set a range for acceptable administrative costs among PIHPs, CMHSPs, and providers. Failure to stay within this range should trigger meaningful sanctions.
- Reduce variation in care through the identification, adoption, and measurement of evidence-based practices that produce positive outcomes for persons with mental illness, moving over time to financial incentives for high-quality care.